TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Physicians Surgical Hospital

Respondent Name
Texas Mutual Insurance

MFDR Tracking Number
M4-17-3476-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
July 27, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We then contacted Amerisure to validate the billing information and submitted the claim within a reasonable timeframe."

Amount in Dispute: $9,223.78

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The requestor's bill is untimely. Texas Mutual received the bill 4/18/17. (Attachment) The creation date of the bill is 4/18/17, a date that exceeds 95 days from 12/13/16, the date of service."

Response Submitted by: Texas Mutual

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
December 12 - 13, 2016	Outpatient Hospital Services	$9,223.78	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §133.20 details procedures of medical bill submission by health care providers.
3. Texas Labor Code §408.0272 details exceptions for untimely submission of health care claims.
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 29 – The time limit for filing has expired
   - 731 – Per 133.20(B) provider shall not submit a medical bill later than the 95th day after the date of service.

- W3 – In accordance with TDI-DWC Rule 134.804, this bill has been identified as a request for reconsideration or appeal
- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed.

Issues

1. Are the insurance carrier's reasons for denial or reduction of payment supported?
2. Has the requestor forfeited their right to reimbursement?

Findings

1. The requestor is seeking reimbursement of $9,223.78 for outpatient hospital services rendered on December 12 – 13, 2016.

   The insurance carrier denied disputed services with claim adjustment reason code 29 – "The time limit for filing has expired."

   The requestor states, "At that time, we were provided incorrect work comp payer information."

   28 Texas Administrative Code §133.20 (b) states in pertinent part,

   > In accordance with subsection (c) of the statute, the health care provider shall submit the medical bill to the correct workers' compensation insurance carrier not later than the 95th day after the date the health care provider is notified of the health care provider's erroneous submission of the medical bill. A health care provider who submits a medical bill to the correct workers' compensation insurance carrier shall include a copy of the original medical bill submitted, a copy of the explanation of benefits (EOB) if available, and sufficient documentation to support why one or more of the exceptions for untimely submission of a medical bill under §408.0272 should be applied.

   Texas Labor Code 408.0272 (b) (1) states in pertinent part,

   > Notwithstanding Section 408.027, a health care provider who fails to timely submit a claim for payment to the insurance carrier under Section 408.027(a) does not forfeit the provider's right to reimbursement for that claim for payment solely for failure to submit a timely claim if:
   >
   > (1) the provider submits proof satisfactory to the commissioner that the provider, within the period prescribed by Section 408.027(a), erroneously filed for reimbursement with:
   >
   > (A) an insurer that issues a policy of group accident and health insurance under which the injured employee is a covered insured;
   >
   > (B) a health maintenance organization that issues an evidence of coverage under which the injured employee is a covered enrollee; or
   >
   > (C) a workers' compensation insurance carrier other than the insurance carrier liable for the payment of benefits under this title;

   Review of the submitted documentation found insufficient evidence to support that a claim was submitted timely to the incorrect workers compensation carrier or explanation of benefits to support an exception of Texas Labor Code 408.0272 exists. Therefore, the requestor was required to submit the claim within 95 days of the date of service. The carrier's denial is supported.

2. As the requirements of 28 Texas Administrative Code §133.20 (b) were not met and insufficient evidence of an exception detailed in Texas Labor Code 408.0272 was found, no additional payment is ordered.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031, the division hereby determines the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

		August 17, 2017
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with Rule §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.